Economic Recovery Advisory Board
Public Health and Healthcare Workgroup
ACCESS TO CARE FOR IOWANS: PARTNERSHIPS
Meeting Notes
August 6, 2020

9:00 a.m. Introductions

Kristin Williams
Lastascia Coleman
Linda Scheid
Anne Gruenewald
Shelley Horak

Kristin gave an overview of the discussion topic for this call as Access to Care for Iowans: Partnerships, and shared that the call today will focus conversation around:

Pandemic Preparation and Response

1. Partnership with employers, health care providers, schools and child care providers.
2. Healthcare innovation.
    a. Social determinants of health (aging, minority and low income populations).
    b. Community health and other non-traditional providers of services.
    c. Analytics, statistics and population health, including investments in data sharing and analytics infrastructure that promotes quality, safety and improvement in health outcomes for populations.
    d. Policy drivers to impact outcomes through Medicaid, Medicare and private insurance.
    e. Strategic investment in services that will advance these goals

GROUP CONVERSATION

Linda Scheid asked what already exists? What's working? Are there gaps? What can we do better/differently? What are the frustrations and challenges?

Deborah Thompson, Iowa Public Health Association volunteer, Advocacy Committee said that for all of the items listed, she wants to be sure that listeners on this call understand that this is all within the public health wheelhouse. Larger agencies are great models for what can be done if you increase capacity. They hire staff that are specifically intended to coordinate the type of partnerships within the local communities. Primarily about building relationships and having tie to do it. For governmental public health, they're intended to cover the entire population. Having them as a central convener to have all these people at the table is going to be critical. It all comes back to increasing the capacity.

Linda said part of the focus today is there are lot of people with passion and skills working in their own little areas. How do we bring those people together and bring that expertise to the table to move our communities forward and adjust to the challenges? What do you want to see done differently?

Erika Shannon said that key counties and regions in the state show us what we could do. We would like an opportunity for some of those star players to come together and share best practices and what went well/didn't, maybe put together a toolkit to use so that we aren't reinventing the wheel.

Deborah Thompson asked if there are any comments on data sharing? Mike Randol talked about data security as an issue for Medicaid not being able to share more readily. Is there a way to invest in those barriers to living data? Iowa Total Care is investing in a particular center in St. Louis to study pilots for interventions. Looks like they use a lot of their data to achieve accrued standards, more can be done with that and can be applied to populations not on Medicaid program.

Lastascia Coleman mentioned there are some places that have best practices, does anyone fall in that category?

Erika Shannon said she was impressed with Sioux City, Black Hawk, Linn, these are the key ones that stuck out to her.

Deborah Thompson mentioned Black Hawk county and asked about how partnership with businesses were formed and how they were able to be a link between the groups as they try to figure out safe operations (Tyson). They had built relationships prior to Covid. Johnson County just incredible progress and prevention. Involved board of health. Engagement of those individuals is also important, can be ambassadors to local communities. Webster County, Kari Prescott, some of the first actions taken around accountable care orgs done in partnership with local hospitals.

Anne Gruenewald asked if any of them are on the call?

Deborah Thompson said on the first couple of calls, she didn't see see overt key words that would bring them to the table this time. Since there was limited time, wouldn't respond to how the agendas are set up.

Jess Wegner, Fayette County Health said in rural settings, three year prior to Covid they had set up a public health group and were meeting monthly prior to Covid. They were doing daily calls at first to assess situation, these calls have gone to once a week now. Those relationships have been extremely valuable. We struggled with the clergy to make sure everyone was up to date. Had a good handle on school officials and nurses. A lot of lists were outdated and it was hard to put them together at the last minute. Relationships in the healthcare field have proved to be beneficial.

Shelley Horak shared information about the social determinants of health workgroup – data sharing is a hot topic, there are all kinds of needs to share data, all kinds of real and perceived barriers and hesitancy. Started during state innovation model, looking at healthcare innovation and how to address social needs of Iowans. Workgroup landed on a core set of standardized SD standards. Other orgs have brought in those standardized measures. We can start to see and develop a picture so we're not guessing. Struggled with a statewide view of that. This group works to try and solve those problems. Augments the work of individual organization but expands that as well. There should be no fear in sharing aggregated social needs data. Help us to do better planning in our organizations and also identify partnerships that are important. With social needs – the group has struggled with identifying the resources to address those needs. Is access to those resources equitable and where do things need to be expanded? There are lots of resource directories, but don't have a statewide view on that. If you are interested in joining, message Shelley and let her know.

Jess Wegner said in our county and state it is important to bring Public Health into the conversation to the topic of where resources are. Most LPHs are doing their community health needs assessments, and are identifying those needs right now, some counties are still working through that. Regular Community Health Needs Assessments and Health Improvement Plans (CHNA HIPs) identify community needs. This

year our approach will be more of reaching out to specific resources on specific health needs and not duplicate services as much. With that, one of our top needs is mental health. This information can be helpful in applying for grants that can help us with data sharing. Adult and childhood obesity, as health concerns, are often pulled in different sectors. If organizations could tie into CHNA HIPs, I would advise this is a way other sectors can be more involved in the public health response. Mental health will be a major component**.**

Shelley Horak wanted to underscore CHNA HIP assessments exist in every single county and are completed every 3-5 years. They identify the most relevant needs in every county and are a really good jumping off option for building partnerships. This group could benefit from knowing about those.

Anne Gruenewald said primary and secondary impacts on Covid, mental health, public health, additional considerations such as affordable housing. Eviction rates could go up. Think in terms of potential high impact area for the populations. To the extent we could aggregate data across entities to address economic factors that are going in the wrong direction, my observations are that there are pilots in segments across the state.

Casey, Iowa Pharmacy Association said building from pockets of innovation and then scaling these, statewide support is the hardest part to bring up to scale. Permanency of financing such as testing from, HHS; we have seen strains on the drug supply system: consistent reimbursement system, things done under executive order should be extended.

Lastascia said some declarations have been helpful such as telehealth which has increased access for rural residents.

Immunization Coalitions representative said there have been significant reduction in immunization rates due to COVID. The governor could make a concerted effort to ensure immunizations are continued to minimize potential for disease outbreaks. Also observing the disparities of those impacted by COVID and one of the issues is trust of the health system. We have looked at some of the things employers could do such as paid leave. Build culture of health around employees and ensure they can stay home when they are sick. Leadership should tackle this hard work of reimagining blending health and economy

Casey said that for immunizations, we can all agree that broad access is necessary. We place arbitrary barriers such as which vaccines pharmacists can provide. What will occur when a vaccine is available for COVID?

Kara Bylund said the Iowa Dental Association would echo IPA's sentiment regarding Medicaid reimbursement as a barrier to access to care to oral health care. Most dentists in Iowa are independent small business owners, and when Medicaid reimburse does not cover the costs associated with delivering care, they are not able to sustain a practice with a high Medicaid payer population.

Casey Ficek said they have seen a lot of innovative responses. Statewide support is most difficult to bring up to scale. Permanency and finding ways to provide consistent reimbursement. Pharmacies providing testing through an HHS pilot there is no opportunity to continue that because of feasibility. Heard a lot of positive feedback, seen a lot of strains on the drug supply system especially at beginning of the pandemic, therapeutic substitutions. That could be extended and continue to serve patients, some of these shortages will drag out for a while. It's a hard question to answer, but adding permanency, consistent reimbursement. Consideration should be given to making those permanent.

Lastascia Coleman said some of the declarations have been really helpful, weren't able to do telehealth and get reimbursed for it with that change it has been helpful to access our patients. Good partnership to continue.

Deborah Thompson said one concern that has come up from immunization coalition is reduction in rates as a result of Covid. Perhaps the Governor could make a concerted effort to ensure parents that it's safe to get immunizations back on track. Encouraging partnerships at local level, need more local partnerships. Disparity around those impacted (immigrants, populations of color) disproportionally impacted. Trust of the healthcare system, what can we do at the local level to increase those relationships. Looked at what employers can do, offering paid leave more often. Nice to build a culture of health around our employees. Sometimes people just want stay home when they're sick. Need political will and leadership to tackle. Reimbursement has come up regularly in policy issues. Reimagining what it looks like to blend the health of a worker and the prosperity of an economy together.

Casey Ficek said immunizations are one thing we need to provide broad access to. Sort of place these arbitrary barriers on which immunization they can provide. Caught in a strange area, confusing for patient. When a vaccine does become available, becomes and interesting question if the pharmacists can provide that. Hopefully there's enough wiggle room. Remove some of those barriers that prevent providers form using all their skills.

Linda asked about healthcare innovation? Social determinacy of health?

Anne Gruenewald said the bottom line is that if we look at what this body of work is attempting to address is not only improving public health, but the economy. Populations that are probably most at risk but also highest cost are those special populations. Very aware that the way we address their needs if we do so separately, we're missing an opportunity to do so in a much more coordinated and efficient way.

Linda mentioned food insecurity. How many opportunities are we missing?

Deborah Thompson said social determinacy of health has taken awhile to pick up steam. When anyone comes in with a need, there should be assessment to understand the whole person. Work with services to match need introducing social determinacy of health. Assessment done on the person then outreach. Again its capacity and not putting in the time because of other things to develop the needs. Community health needs assessment, we should be beefing up that process. Education at the most basic, investment in non-clinical professions.

Lastascia Coleman said this goes back to work in maternal health and workforce issues with maternal health. Midwives are going to be a very useful and needed solution to our healthcare crisis on maternal side. Workforce already has a shortage. Need to get midwives into the community. Community health workers and dual services. 50% of maternal deaths happen in post-partum. Having community access to someone that they can be in touch with would be an innovative model to try to implement with locals.

Anne Gruenwald said that Covid has got these people mostly in survival mode. To think in terms of more forward planning while at the same time trying to keep head above water requires some masterful toggling. If folks feel as though the contributions to this work group is more to make sure that those we serve don't fall further behind as opposed to being more innovative and progressive.

Deborah Thompson said we need manpower to get to the point where I can think, most not even there. Been a constant erosion of support have been published that we haven't even rebounded. But challenge us to look further upstream to understand who we can put in place to prevent such a heavy demand. Every single profession has complied about reimbursement. Need to challenge ourselves to invest in professions that aren't as costly like PH professionals and social workers. Etc. need to prevent these issues before they happen in the first place.

Jennifer Vermeer said the small size of many public health offices, one thing that has struck during pandemic when we think about surge planning, IDPH has hospital regions, in our region 5 we got all the people together and created a regional plan. It's not realistic to think that everyone can offer everything to everyone. We function in a much more regional sense. Should part of the response be a greater thought process to both systems of care and the intersection? Got to have enough employment and infrastructure. Everything has to fit together to make things really work. Think of that from a regional standpoint. Think about how counties can work together across regions.

Deborah Thompson said population health means something different to different people. What is the best place to house an analytical system? IDPH, DHS or ISU? Who has the skill sets to do this work? Getting money for our system was difficult. IT is expensive.

Jennifer Vermeer said there was a center of excellence or system of care model that was discussed early in the session from the governor's office. Put out some funding that areas could come together in a regional approach to see what might be needed. If we were to come together to make sure we have an adequate system of care, together in a region we are able to provide that comprehensive care with a link to a larger center. This would enable entities to come together and think about this geographically. The idea is joint to the economic conversation. We want a robust economy where there's enough privatized balanced within. How do you recruit from a diverse population to train workers to do many things? Increasing medical complexity of the population that lives in rural Iowa.

Deborah Thompson asked who is the convener of those conversations.

Jennifer Vermeer said start with some finding to attract. Applicants would have to be a series of partners that would come forward with a center of ideas. Idea at the time is to put some funding for people to respond to as a grant process. What time horizon are we talking about? What are the main things that would help right now but also help down the road?

Deborah Thompson mentioned community needs assessments. Plans that identify specific county needs and beginning strategies. IDPH will look at a state perspective. We already have a loose infrastructure that can be improved. Prevention especially with chronic and complex needs to be prioritized and we already have a loose structure in place.

Jennifer Vermeer said not just public entities, but business and community leaders. Needs to be owned by those folks.

Lastascia Coleman said we need a statewide effort to look at those hospitals and identify who's in trouble but also have a policy in place to help them or have a regional strategy.

Laura Jackson said one of the things through the Wellmark lens is looking to partner with rural hospitals. What's happening in these small communities with older folks getting sicker and fall into two government programs? We have to think bigger and holistically, not enough money coming from the private sector. How do we start to think regionally? Wellmark wants to be a part of that.

Shelley said no one knows the problems, has identified priorities, has associated them with geography, and therefore can't articulate solutions. She advised she would avoid incentivizing work based on an RFP. Do we have dramatically different solutions?

Laura said what if we took the CHNAs and if we were starting all over again what would we do differently? If people were going to live healthy lives what needs to occur? Shelley shared the Institute for Alternative Futures has a model that could be used to re-imagine health and health care partnerships: https://www.altfutures.org/

Deborah Thompson asked for any reasons not to do this?

Laura said money driving care is too much of a focus. We have to drive the quality first.

Anne said the notion is to make it worthwhile to do that planning work at the regional level.

Linda said there is a need for change, but it is difficult, perspectives are important to expand our view of the issues and the opportunities.

Deborah Thompson said I agree with Anne funding drives work, there should be public private partnerships. Economic incentives to start the conversations, political will governor give authority for primary convener to ask for people to participate to ensure others come to the table.

CHAT NOTES:

From Matt Highland:
You can find previous meeting notes and other information on the group here:
https://dhs.iowa.gov/Economic_Recovery_Advisory_Board_Public_Health_and_Healthcare_Workgroup
Reminder: Tomorrow is deadline to submit written comment, which can be emailed to:
COVIDAdvisoryBoard@dhs.state.ia.us

From Kara Bylund- IDA:
The Iowa Dental Association would echo IPA's sentiment regarding Medicaid reimbursement as a barrier to access to care to oral health care. Most dentists in Iowa are independent small business owners, and when Medicaid reimburse does not cover the costs associated with delivering care, they are not able to sustain a practice with a high Medicaid payer population.

From Samantha Cannon:
Social determinants of health work is incredibly important, but the current reimbursement structure does limit capacity building.

From debralkazmerzak:
There are grant funded efforts underway in Iowa to promote and support utilization of community health workers in Iowa. Iowa Chronic Care Consortium has partnered with DMACC and a variety of employers in this work. It seems like a perfect time for the state to consider a more coordinated, larger scale effort to support adoption of CHWs, as has already occurred in most other states.

From ann.cochran:
I would suggest that a smaller county health dept. may be more nimble and ready to make changes.

Workgroup Leadership: *Randy Edeker, Suresh Gunasekaran, Kelly Garcia*
Workgroup Members: Kristin Williams, Jorge Salinas, MD, Anne Gruenewald, Brooke Lovelace, Laura Jackson, Samantha Cannon, Matt Wenzel, Michelle Krefft, Lastascia Coleman, Linda Scheid, Lindee Thomas, Robb Gardner, Dr. Pedati (ex-officio), Linda Miller (ex-officio).